STATE OF NEVADA
DEPARTMENT OF PERSONNEL

REQUEST FOR TEMPORARY ADJUSTMENT TO SALARY

(Special Adjustment Equivalent to One Grade - NAC 284.206)

ORG. NO. _____ DEPARTMENT _____ DIVISION _____

EMPLOYEE NAME _____ PHONE NO. _____

POSITION CONTROL NO. _____ GEOGRAPHIC LOCATION OF POSITION _____

CLASS TITLE _____ CLASS CODE _____

BASIS OF REQUEST: *(Items listed below are abbreviated. Read NAC 284.206 for qualifying conditions. Attach explanation.)*

- ☐ Employee is temporarily working out of class on a continuing basis. Date duties assumed _____
  Class title and code of higher position for which duties are performed _____
- ☐ Employee uses bilingual skills or sign language for the deaf at least 10% of work time.
- ☐ Employee supervises other employee(s) of the same or higher grade and such supervision is not provided for in one class specification.
  Attach an Organizational Chart. *Check factors that apply:*
  ☐ Selection ☐ Work Assignment ☐ Training ☐ Performance Appraisal ☐ Work Review ☐ Discipline
- ☐ MH/DS, DCFS or Corrections (inpatient mental health) employee:
  ☐ Who regularly performs custodial work **and** cleans up human bodily wastes.
  ☐ Whose principal place of work is an assaultive environment as determined by administrator **and** who provides medical treatment, maintains buildings, instructs academic courses or provides therapy.
- ☐ Employee conducts a formal training program for employees in an occupational class series.
- ☐ Law enforcement officer assigned to motorcycle duty.
- ☐ Corrections employee who is required to supervise inmates if such duties are not provided for in the class specification.
- ☐ Other (*describe*)

.....

.....

CERTIFICATION

I certify the information provided in this document and in the attachment is accurate. I agree to have the adjustment removed when it expires per NAC 284.206 (1)(a) or, if approved pursuant to another subsection of the regulation, when the conditions justifying it cease to exist.

_____ _____ _____

Signature of Appointing Authority or Designated Representative | Date Signature of Employee* | Date

- Employee signature required only if submitted without appointing authority certification. *(Personnel will process the request but will verify the information with the appointing authority.)* Employee signature attests only to accuracy of information; if approved, appointing authority will be apprised of responsibility to remove adjustment upon expiration.

FOR COMPLETION BY DEPARTMENT OF PERSONNEL

☐ APPROVED Effective _____ Per NAC 284.206 Subsection _____ Expires ☐ Date _____

OR

☐ DISAPPROVED Study No. _____ ☐ When Justifying Conditions Cease to Exist (*whichever is sooner*)

Signature _____ Date _____

ATTACH COPY OF APPROVED DOCUMENT TO PAYROLL FORM (ESMT-A)

NPD-5 (6-01)
MEK:cp